STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155149	A. BUILDING _____ B. WING _____	C 12/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARCOURT TERRACE NURSING AND REHABILITATION	**8181 HARCOURT RD INDIANAPOLIS, IN 46260**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the investigation of Complaint IN00140941. This visit was in conjunction with the recertification and State Licensure survey. This visit was in conjuction with the investigation of Complaint IN00140424. Complaint IN00140941: Unsubstantiated due to lack of evidence. Survey dates: December 2, 3, 4, 5, 6 & 10, 2013 Facility number: 000070 Provider number: 155149 AIM number: 100266190 Survey team: Gloria Bond, RN Team Coordinator Janet Stanton, RN Sandra Nolder, RN Census bed type: SNF: 8 SNF/NF: 86 Total: 94 . Census payor type: Medicare: 12 Medicaid: 72 Other: 10 Total: 94 Sample: 7 Harcourt Terrace Nursing and Rehabilitation was	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155149	A. BUILDING _____ B. WING _____	C 12/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARCOURT TERRACE NURSING AND REHABILITATION	**8181 HARCOURT RD INDIANAPOLIS, IN 46260**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the investigation of Complaint IN00140941. Quality Review was completed by Tammy Alley RN on December 17, 2013.	F 000		